STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING _____ B. WING _____	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE VILLAGE NURSING & REHAB CENTER	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00139528.

Complaint IN00139528 Substantiated. Federal/ State deficiency related to the allegations is cited at F333.

This resulted in a partially extended survey-Past Non Compliance Immediate Jeopardy.

Survey dates: November 20, and 21 2013

Facility number: 011296
Provider number: 155763
AIM number: 200827620

Survey team:
Christine Fodrea, RN

Census bed type:
SNF/NF: 59
Residential: 7
Total: 66

Census payor type:
Medicare: 11
Medicaid: 36
Other: 19
Total: 66

Sample: 4

These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.

Quality Review completed on November 21, 2013 by Randy Fry RN.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING _____ B. WING _____	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE VILLAGE NURSING & REHAB CENTER	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow their policy and procedure for cross checking Medication Administration Record transcription for accuracy after month end change over and failed to ensure the administration of the correct dose of an anticoagulant medication, which resulted in hospitalization for 1 of 4 residents reviewed for the use of anti-coagulant medications in a sample of 4. (Resident #D) Due to the lack of cross checking for transcription errors, this deficient practice had the potential to affect 6 of 6 residents receiving anticoagulant therapy of the 59 residents residing on the health care units of the facility. The Immediate Jeopardy began on 11/1/13 when Resident #D received the incorrect dose of Coumadin (an anticoagulant medication) and the error was not identified until 11/04/13 when the nurse administering medication caught the error. Resident #D required hospitalization for stabilization of the PT/INR (Prothrombin Time/International Normalized Ratio) after two consecutive critical PT/INR results. The facility Director of Nursing was informed of the Immediate Jeopardy on 11/20/13 at 12:17 p.m. The Immediate Jeopardy was removed on 11/6/13 when the facility completed audits of all medication records for accuracy, re-educated the nurse who made the errors in monthly change	F 333	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING _____ B. WING _____	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE VILLAGE NURSING & REHAB CENTER	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 2	F 333		

over transcription, and inserviced all nursing staff on medication orders. The immediate jeopardy was corrected on 11/12/13 when the facility completed all medication audits and the Consultant Pharmacist reviewed all residents receiving coumadin. The correction date was prior to the start of the survey and was therefore Past Noncompliance.

Findings include:

The record for Resident #D was reviewed on 11/20/13 at 10:30 a.m. The resident's diagnose's included, but were not limited to, atrial fibrillation, dementia with delusions, high blood pressure, and depression. The resident was sent to the hospital on 11/05/13 and was readmitted to the facility on 11/06/13.

Review of the October 2013 Physician orders included an order written on 10/30/13 for the resident to receive Coumadin (a medication to prevent blood clotting risk) 1.5 milligrams (mg) orally every evening at 5:00 p.m. An order was written on 10/4/13 for the resident to have a PT/INR laboratory level drawn on 11/6/2013.

The October 2013 MAR (Medication Administration Record) was reviewed. The MAR indicated the resident was receiving Coumadin for a diagnosis of atrial fibrillation (an irregular heartbeat). The ordered dose of Coumadin 1.5 milligrams was given as ordered on 10/30 and 10/31/13.

The November 2013 MAR (Medication Administration Record) was reviewed. The MAR had a handwritten entry. The entry indicated Coumadin 7.5 mg was given on 11/01, 11/02 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING _____ B. WING _____	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE VILLAGE NURSING & REHAB CENTER	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 3	F 333		

11/03/13. On 11/04/13, the entry was circled, and beneath the entry was handwritten an order for Coumadin 1.5 mg to be given by mouth every day. The entry indicated Coumadin 1.5 mg was given on 11/04/13 at 5 p.m.

An untimed physician's order dated 11/04/13 indicated to draw a PT/INR stat (now).

The PT/INR results dated 11/04/13 indicated the PT was more than 100 (normal is 9.4 to 11.4), and the INR was more than 9.2 (normal is 0.9 to 1.1). The results were noted to be a "critical level".

A physician's order dated 11/04/13 at 8 p.m. indicated to hold the Coumadin, give Vitamin K 7.5 mg now and recheck the PT/INR on 11/05/13. Vitamin K 5 milligrams IM was also signed out as given on 11/04/13 at 4:00 p.m.

The PT/INR results dated 11/05/13 indicated the PT was still more than 100 and the INR results were more than 9.2. The results remained in a "critical level".

Review of the 12th Edition of the "Geriatric Dosage Handbook" included INR ranges based on indication of use (page 1650). The targeted INR for the treatment of atrial fibrillation was 2.5 with a targeted range of 2.0-3.0.

On 11/05/2013 at 2:25 p.m., a physician's order was written to directly admit Resident #D to the Hospital due to critical PT/INR.

When interviewed on 11/20/13 at 11:24 a.m., the Director of Nursing (DON) indicated a staff nurse recognized the Coumadin dose was suspect on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING _____ B. WING _____	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE VILLAGE NURSING & REHAB CENTER	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 4	F 333		

her tour of duty on 11/04/13 and called the pharmacy to double check. The pharmacy indicated to the nurse the 7.5 mg dosage was incorrect. The staff nurse then called the physician and reported the error. Resident #D was sent to the hospital on 11/05/13. The DON indicated the facility reviewed it's policy regarding cross checking transcription after the monthly change over. The changeover nurse was to double check the transcription on the MAR for the coming month with the medication indicated the previous month, then if a discrepancy existed, the nurse was to double check the order. The DON indicated the nurse completing the changeover did not double check with the previous month's MAR, and therefore did not catch the mistake.

The Past Noncompliance Immediate Jeopardy began on 11/01/13. The Immediate Jeopardy was removed on 11/6/13 when the facility completed audits of all medication records for accuracy, re-educated the nurse who made the errors in monthly change over transcription, and inserviced all nursing staff on medication orders. The immediate jeopardy was corrected on 11/12/13 when the facility implemented a systemic plan that included the following actions: All medication audits were completed, the Consultant Pharmacist reviewed all residents receiving coumadin, Physician orders, laboratory test results, and verification of the correct medications were completed. The correction date was prior to the start of the survey and was therefore Past Noncompliance.

This federal tag relates to Complaints IN00139528.

3.1-25(b)(9)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING _____ B. WING _____	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE VILLAGE NURSING & REHAB CENTER	**600 TRAIL RIDGE RD ALBION, IN 46701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE